FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States and CMS over the years to design and revise this Annual Report Template. Over time, the framework has been updated to reflect program maturation and corrected where difficulties with reporting have been identified.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **Montana**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)
John Chappuis, Acting Director

SCHIP Program Name(s): Montana Children's Health Insurance Plan

SCHIP Program Type:

_____ SCHIP Medicaid Expansion Only
X Separate Child Health Program Only
_____ Combination of the above

Reporting Period: *Federal Fiscal Year 2004* *Note: Federal Fiscal Year 2004 starts 10/1/03 and ends 9/30/04.*

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Submission Date: January 4, 2005

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. You are encouraged to complete this table for the different SCHIP programs within your state, e.g., if you have two types of separate child health programs within your state with different eligibility rules. If you would like to make any comments on your responses, please explain in narrative below this table. Please note that the numbers in brackets, e.g., **[500]** are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

	SCHIP Medicaid Expansion Program					**Separate Child Health Program**				
Eligibility						**From**		% of FPL conception to birth	**0**	% of FPL
	From		% of FPL for **infants**		% of FPL	**From**		% of FPL for **infants**	150	% of FPL
	From		% of FPL for children ages **1 through 5**		% of FPL	**From**		% of FPL for 1 **through 5**	150	% of FPL
	From		% of FPL for children ages **6 through 16**		% of FPL	**From**		% of FPL for children ages **6 through 16**	150	% of FPL
	From		% of FPL for children ages **17 and 18**		% of FPL	**From**		% of FPL for children ages **17 and 18**	150	% of FPL

Is presumptive eligibility provided for children?		No	X	No
		Yes, for whom and how long? **[1000]**		Yes, for whom and how long? **[1000]**

Is retroactive eligibility available?		No	X	No
		Yes, for whom and how long? **[1000]**		Yes, for whom and how long? **[1000]**

Does your State Plan contain authority to implement a waiting list?	Not applicable		No
		X	Yes

Does your program have a mail-in application?		No		No
		Yes	X	Yes

Can an applicant apply for your program over the phone?		No	X	No
		Yes		Yes

Does your program have an application on your website that can be printed, completed and mailed in?		No	X	No
		Yes		Yes

Can an applicant apply for your program on-line?		No	X	No
	Yes – please check all that apply		Yes – please check all that apply	
		Signature page must be printed and mailed in		Signature page must be printed and mailed in
		Family documentation must be mailed (i.e., income documentation)		Family documentation must be mailed (i.e., income documentation)
		Electronic signature is required		Electronic signature is required
				No Signature is required

Does your program require a face-to-face interview during initial application		No	X	No
		Yes		Yes

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?		No		No
		Yes	X	Yes
	Specify number of months		Specify number of months	3

Does your program provide period of continuous coverage <u>regardless of income changes?</u>		No		No
		Yes	X	Yes
	Specify number of months		Specify number of months	12
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	
	[1000]		If a child dies, turns age 19, moves from Montana, moves without notifying SCHIP and we are unable to locate the family, is Medicaid eligible, becomes eligible for Montana state/university employee health insurance or is found to have other creditable health insurance coverage, coverage may be less than 12 months. NOTE: Twelve months of eligibility does not necessarily mean 12 months of enrollment due to time spent on the waiting list.	

Does your program require premiums or an enrollment fee?		No	X	No
		Yes		Yes
	Enrollment fee amount		Enrollment fee amount	

	Premium amount		Premium amount	
	Yearly cap		Yearly cap	
	If yes, briefly explain fee structure in the box below		If yes, briefly explain fee structure in the box below (including premium/enrollment fee amounts and include Federal poverty levels where appropriate)	
	[500]		**[500]**	

Does your program impose copayments or coinsurance?		No		No
		Yes	X	Yes

Does your program impose deductibles?		No	X	No
		Yes		Yes

Does your program require an assets test?		No	X	No
		Yes		Yes
	If Yes, please describe below		If Yes, please describe below	
	[500]			

Does your program require income disregards?		No		No
		Yes	X	Yes
			If Yes, please describe below	
			$1,440 annual work disregard for each earner $2,400 annual dependent care disregard for each individual receiving care	

Is a preprinted renewal form sent prior to eligibility expiring?		No		No
	Yes, we send out form to family with their information pre-completed and		Yes, we send out form to family with their information pre-completed and	
		We send out form to family with their information pre-completed and ask for confirmation	X	We send out form to family with their information pre-completed and ask for confirmation. Information must be updated.
		We send out form but do not require a response unless income or other circumstances have changed		We send out form but do not require a response unless income or other circumstances have changed

Comments on Responses in Table:

2. Is there an assets test for children in your Medicaid program? [X] Yes [ ] No

3. Is it different from the assets test in your separate child health program? [X] Yes [ ] No
Note: SCHIP does not have an assets test.

4. Are there income disregards for your Medicaid program? [X] Yes [ ] No

5. Are they different from the income disregards in your separate child health program? [X] Yes [ ] No

6. Is a joint application used for your Medicaid and separate child health program? [X] Yes [ ] No

7. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program		Separate Child Health Program	
	Yes	No Change	Yes	No Change
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)				X
b) Application				X
c) Benefit structure				X
d) Cost sharing (including amounts, populations, & collection process)				X
e) Crowd out policies				X
f) Delivery system				X
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)			X	
h) Eligibility levels / target population				X
i) Assets test in Medicaid and/or SCHIP				X
j) Income disregards in Medicaid and/or SCHIP			X	
k) Eligibility redetermination process				X
l) Enrollment process for health plan selection				X
m) Family coverage				X
n) Outreach (e.g., decrease funds, target outreach)			X	
o) Premium assistance				X
p) Prenatal Eligibility expansion				X

q) Waiver populations (funded under title XXI)				
Parents				X
Pregnant women				X
Childless adults				X
				X

r) Other – please specify

a.	**[50]**			
b.	**[50]**			
c.	**[50]**			

8. For each topic you responded yes to above, please explain the change and why the change was made, below:

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	
c) Benefit structure	
d) Cost sharing (including amounts, populations, & collection process)	
e) Crowd out policies	
f) Delivery system	
g) Eligibility determination process (Including implementing a waiting lists or open enrollment periods)	SCHIP qualifying children, who are closing off Medicaid without an SCHIP enrolled sibling, are placed on the waiting list. They are enrolled as funding becomes available. All individuals residing in the household are counted as family members and their income is also counted as family income. After screening for Medicaid eligibility, SCHIP coverage is available to qualifying children residing in the household regardless of their relationship to the head of household.
h) Eligibility levels / target population	
i) Assets test in Medicaid and/or SCHIP	

j) Income disregards in Medicaid and/or SCHIP	A family is credited with a $1,440 annual income disregard for each individual receiving earned income. A family is credited with a $2,400 annual income disregard for each family member receiving dependent care.
k) Eligibility redetermination process	
l) Enrollment process for health plan selection	
m) Family coverage	
n) Outreach	To encourage Native Americans to apply for SCHIP, staff visited several tribes, attended Powwows throughout the state plus the Native American Indian Women's Health Conference. Staff also visited with employees of companies who were facing imminent lay-offs.
o) Premium assistance	
p) Prenatal Eligibility Expansion	
q) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
r) Other – please specify	
a. **[50]**	
b. **[50]**	
c. **[50]**	

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

This section consists of three sub sections that gather information on the core performance measures for the SCHIP program as well as your State's progress toward meeting its general program strategic objectives and performance goals. Section IIA captures data on the core performance measures to the extent data are available. Section IIB captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your State. Section IIC captures progress towards meeting your State's general strategic objectives and performance goals.

Please note that the numbers in brackets, e.g., [500] are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

CMS is directed to examine national performance measures by the SCHIP Final Rules of January 11, 2001. To address this SCHIP directive, and to address the need for performance measurement in Medicaid, CMS, along with other Federal and State officials, developed a core set of performance measures for Medicaid and SCHIP. The group focused on well-established measures whose results could motivate agencies, providers, and health plans to improve the quality of care delivered to enrollees. After receiving comments from Medicaid and SCHIP officials on an initial list of 19 measures, the group recommended seven core measures, including four child health measures and three adult measures:

Child Health Measures
- Well child visits in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th, and 6th years of life
- Use of appropriate medications for children with asthma
- Children's access to primary care practitioners

Adult Measures
- Comprehensive diabetes care (hemoglobin A1c tests)
- Adult access to preventive/ambulatory health services
- Prenatal and postpartum care (prenatal visits)

These measures are based on specifications provided by the Health Plan Employer Data and Information Set (HEDIS®). HEDIS® provides a useful framework for defining and measuring performance. However, use of HEDIS® methodology is not required for reporting on your measures. The HEDIS® methodology can also be modified based on the availability of data in your State.

The table should be completed as follows:

Column 1: If you cannot provide a specific measure, please check the boxes that apply to your State for each performance measure, as follows:
- Population not covered: Check this box if your program does not cover the population included in the measure. For example, if your State does not cover adults under SCHIP, check the box indicating, "population not covered" for the three adult measures.
- Data not available: Check this box if data are not available for a particular measure in your State. Please provide an explanation of why the data are currently not available.
- Not able to report due to small sample size: Check this box if the sample size (i.e., denominator) for a particular measure is **less than 30**. If the sample size is less 30, your State is not required to report data on the measure. However, please indicate the exact sample size in the space provided.
- Other: Please specify if there is another reason why your state cannot report the measure.

Column 2: For each performance measure listed in Column 1, please indicate the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®). If the measures were calculated using HEDIS® or HEDIS®-like specifications, please indicate which version was used (e.g., HEDIS® 2004).

Column 3: For each performance measure listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please also note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, etc. and an explanation for changes from the baseline. Note: you do not need to report data for all delivery system types. You may choose to report data for only the delivery system with the most enrollees in your program.

NOTE: **Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.**

Measure	Measurement Specification	Performance Measures and Progress
Well child visits in the first 15 months of life Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	X HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): Data gathered by BCBS of Montana for SCHIP using administrative data. **[500]** Definition of Population Included in Measure: Standard HEDIS definition. Enrollees who turned 15 months old during the measurement year. **[700]** Baseline / Year: 2002 (Specify numerator and denominator for rates) Numbers too small to report. **[500]** Performance Progress/Year: 2003 (Specify numerator and denominator for rates) Denominator = 45 Numerator: 0 visits = 5 (11.11%) 1 visit = 3 (6.67%) 2 visits = 2 (4.44%) 3 visits = 6 (13.33%) 4 visits = 10 (22.22%) 5 visits = 13 (28.89%) 6+ visits = 6 (13.33%) **[7500]**

Measure	Measurement Specification	Performance Measures and Progress
		Explanation of Progress: In previous years our numbers were so small, we were unable to report this data. **[700]** Other Comments on Measure: **[700]**

Measure	Measurement Specification	Performance Measures and Progress
Well child visits in children the 3rd, 4th, 5th, and 6th years of life Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	X HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): Data gathered by BCBS of Montana for SCHIP using administrative data. **[500]** Definition of Population Included in Measure: Standard HEDIS definition. Enrollees who are 3, 4, 5 & 6 years old. **[700]** Baseline / Year: 30.95% / FFY 2003 (Specify numerator and denominator for rates) **[500]** Performance Progress/Year: 29.01% / FFY 2004. This is a 1.94% decrease from FFY 2003. (Specify numerator and denominator for rates) Numerator = 322 Denominator = 1,110 **[7500]** Explanation of Progress: There was a 1.94% decrease in the number of children who had well-child visits. **[700]** Other Comments on Measure: SCHIP continues to educate families of the importance and availability of well child visits. **[700]**
Use of appropriate medications for children with asthma Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	X HEDIS Specify version of HEDIS used: 2004 (To avoid including children prescribed leukotriene modifiers for allergic rhinitis, the eligible population (denominator) must also have a diagnosis of asthma.) □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): Data gathered by BCBS of Montana for SCHIP using administrative data. **[500]** Definition of Population Included in Measure: Enrollees with persistent asthma who were prescribed medications acceptable as primary therapy for long-term control of asthma. **[700]** Baseline / Year: (Specify numerator and denominator for rates) Not previously measured **[500]**

Measure	Measurement Specification	Performance Measures and Progress
		Performance Progress/Year: 54.22% / FFY 2004 (Specify numerator and denominator for rates) Numerator = 90 Denominator = 166 **[7500]** Explanation of Progress: Not previously measured **[700]** Other Comments on Measure: **[700]**
Children's access to primary care practitioners Not Reported Because: □ Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	X HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): Data gathered by BCBS of Montana for SCHIP using administrative data. **[500]** Definition of Population Included in Measure: Children who were continuously enrolled during the reporting period with no more than one break in enrollment of up to 45 days during the reporting year. Additionally, the 7 to 11 year olds also had to be enrolled during the preceding year. **[700]** Baseline / Year: FFY 2003 (Specify numerator and denominator for rates) 12 – 24 months: 94.73% 2 – 6 years: 80.21% 7 – 11 years: 83.24% **[500]** Performance Progress/Year: FFY 2004 (Specify numerator and denominator for rates) 12–24 mo: 115 / 123 93.50% (-1.23%) 2–6 yrs: 1,034 /1,298 79.66% (- .55%) 7–11 yrs: 1,205 /1,408 85.58% (+2.34%) 12–19 yrs: 1,757 /1,999 87.89% **[7500]**

Measure	Measurement Specification	Performance Measures and Progress
		Explanation of Progress: CHIP continues to educate families about the health care services available to them. The program also continues to recruit CHIP providers statewide to ensure access to care. **[700]** Other Comments on Measure: **[700]**
Adult Comprehensive diabetes care (hemoglobin A1c tests) Not Reported Because: **X** Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress/Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
Adult access to preventive/ambulatory health services Not Reported Because: **X** Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress/Year: (Specify numerator and denominator for rates) **[7500]**

Measure	Measurement Specification	Performance Measures and Progress
		Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
Adult Prenatal and postpartum care (prenatal visits): □ **Coverage for pregnant women over age 19 through a demonstration** □ **Coverage for unborn children through the SCHIP state plan** □ **Coverage for pregnant women under age 19 through the SCHIP state plan** Not Reported Because: **X** Population not covered □ Data not available Explain: □ Not able to report due to small sample size (less than 30) Specify sample size: □ Other Explain: **[500]**	□ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress/Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

SECTION IIB: ENROLLMENT AND UNINSURED DATA

1. The information in the table below is the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by SARTS through a link to SEDS. Please wait until you have an enrollment number from SEDS before you complete this response.

Program	FFY 2003	FFY 2004	Percent change FFY 2003-2004
SCHIP Medicaid Expansion Program			
Separate Child Health Program	**13,084**	**15,281**	**16.79%**

1. Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent.

   In November 2003, the governor allocated $609,900 in one time funds to enroll children who were on Montana's waiting list. The immediate result was elimination of the waiting list. However, the waiting list was reinstated in June 2004. Effective July 2004, the average monthly enrollment was capped at 10,900. **[7500]**

2. Three-year averages in the number and/or rate of uninsured children in each state based on the Current Population Survey (CPS) are shown in the table below, along with the percent change between 1996-1998 and 2001-2003. Significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3. SARTS will fill in this information automatically, but in the meantime, please refer to the CPS data attachment that was sent with the FY 2004 Annual Report Template.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error
1996-1998	**32**	**5.2**	**12.0**	**2.0**
1997-1999	**33**	**5.3**	**12.8**	**1.9**
2000-2002	**20**	**3.6**	**8.8**	**1.5**
2001-2003	**21**	**3.7**	**9.2**	**1.5**
Percent change 1996-1998 vs.	**- 34.4**	NA	**- 23.7**	NA

2001-2003				

A. Please note any comments here concerning CPS data limitations that may affect the reliability or precision of these estimates.

CPS data: Of particular concern is systematic under-or over- counting of children in different states. In Montana, under-counting exists, as evidenced by Montana –specific data obtained through the HRSA State Health Planning Grant. CPS indicates 21,000 uninsured, low-income children for the 2001-2003 period. Montana specific data indicates 35,900 uninsured, low-income children, a 59% undercount by CPS.

In October 2003, a report from the State Health Access Data Assistance Center (SHADAC) indicated that between 1999 and 2002 state funding allocations fluctuated on average 22% per state, or about $18.5 million up or down. The only way a state can receive additional funds for eligible children is increasing as a percent of the national total its population of low-income insured and uninsured children.

[7500]

3. If your State has an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please report in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

Data source(s)	**[500]** Montana Household Survey
Reporting period (2 or more points in time)	**[200]** December 2002 to May 2003
Methodology	**[7500]** The Montana Household Survey was conducted as a stratified random digit dial telephone survey. The data were collected by the Survey Research Center at the University of Montana – Missoula, Bureau of Business and Economic Research. The sample for the survey consisted of telephone numbers stratified by groups of telephone exchanges. The strata were created to as closely as possible resemble county and sub-county geography of the areas to be sampled. Within each stratum, each telephone number had an equal probability of selection for the survey. The survey collected information on the health insurance status of each person in the household and some demographic information about the primary wage earner in the household. The response rate was 75.2%. Statistical weights were constructed to adjust for the fact that not all of the survey respondents were selected with the same probability, and to adjust for different response rates in different groups. Across the different geographic strata, telephone numbers were sampled with different probabilities, in order to achieve the survey objectives of obtaining a certain number of completed interviews in particular geographic areas. Weights were calculated for age and gender. Households with more than one telephone line had a higher chance of being selected for participation in the survey than households with only one telephone line. Those households that purchased individual insurance policies had a higher incidence of multiple telephones. Those with lower incomes were somewhat more likely to have been without a telephone in the last 12 months. The uninsured rate is conservative; weighting for telephone availability would increase the rate and number of uninsured.
Population	**[500]** All Montanans
Sample sizes	**[200]** A total of 5,074 interviews were completed. Total household contacts were 6,747.
Number and/or rate for two or more points in time	**[200]** For the age group 0 through 18, 17%, or approximately 41,723 children were uninsured at all income levels. 35,900 uninsured children live in households at or below 200% FPL.

Statistical significance of results	**[200]** 95% confidence interval

A. Please explain why the state chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children.

Because of the way the 2003 Household Survey was designed, Montana is able for the first time to make detailed estimates of uninsured rates for various population groups within the state, including children ages 0 through 18. Montana CHIP insures children living in households with incomes at or below 150% FPL. CHIP enrollment is limited by funds provided by the state. Unlike many states, Montana had no trouble finding and insuring eligible children, and in fact has had a waiting list for enrollment almost every month during the past three years. Although Montana has not spent its federal allotment in the past, because CPS estimates of uninsured children are low for Montana, the state would have depleted federal funds long ago if state-matching funds had been higher.

Montana would like its federal allotment based on a true picture of the number of uninsured children in the state. A significant number of people living in Montana are low income, work for small employers that cannot afford to provide health coverage benefits, and must travel long distances to access health care. In order to begin building a strong economy, Montana must have access to a strong, healthy, educated work force. Access to health care for children can make a difference in the future of the state.
[7500]

B. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

The State has confidence in the reliability of the estimate of uninsured children established by the Montana Household Survey. The Montana Department of Public Health and Human Services, in collaboration with the University of Montana's Bureau of Business and Economic Research and with technical assistance from the State Health Access Data Assistance Center (SHADAC), University of Minnesota, was supported by a grant from the Health Resources and Services Administration, U.S. Department of Health and Human Services. The Research and Analysis Bureau of the Montana Department of Labor and Industry provided additional data and assistance.

The sample size for the 2003 Household Survey was much larger than other samples used for estimating Montana's uninsured rates, such as the Census population Survey (approximately 1,500 households) or the Behavioral Risk Factor Survey (3,100 Montana adults) conducted by the Centers for Disease Control.

Like all surveys, the findings from the 2003 Household Survey have a margin of error associated with them. This five percent margin of error reflects the fact that there is always uncertainty involved in the process of creating statewide estimates from a representative sample of the population.
[7500]

4. How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information. ***(States with only a SCHIP Medicaid Expansion Program should skip this question)***

CHIP has no data on the number of children enrolled in Medicaid as a result of CHIP outreach activities and enrollment simplification. Applications for Montana CHIP are screened for possible Medicaid eligibility. If a child appears to be eligible for Medicaid, the application is sent to the child's county Office of Public Assistance for a determination of Medicaid eligibility.

[7500]

SECTION IIC: STATE STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

In the table below, summarize your State's general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Use additional pages as necessary. **Please do not reference attachments in this table. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.** The table should be completed as follows:

Column 1: List your State's general strategic objectives for your SCHIP program and indicate if the strategic objective listed is new/revised or continuing. If you have met your goal and/or are discontinuing a strategic objective or goal, please continue to list the objective/goal in the space provided below, and indicate that it has been discontinued, and provide the reason why it was discontinued. Also, if you have revised a goal, please check "new/revised" and explain how and why it was revised.

Note: States are required to report objectives related to reducing the number of uninsured children. (This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3. Progress towards reducing the number of uninsured children should be reported in this section.)

Column 2: List the performance goals for each strategic objective. Where applicable, provide the measurement specification (i.e., were the measures calculated using the HEDIS® technical specifications, HEDIS®-like specifications, or some other source with measurement specifications unrelated to HEDIS®).

Column 3: For each performance goal listed in Column 1, please indicate the data source(s); the definition of the population included in the measure (such as age, continuous enrollment, type of delivery system); the methodology used; the baseline measurement and baseline year; and your current performance, including the date of the most recent data reported. For rates, please specify the numerator and denominator that were used to calculate the rates. Please note any comments on the performance measures or progress, such as data limitations, comparisons with external benchmarks, or the like.

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
Objectives Related to Reducing the Number of Uninsured Children *(Mandatory for all states for each reporting year) (This/these measure(s) should reflect what was reported in Section IIB, Question(s) 2 and 3.)*		
□ New/revised X Continuing □ Discontinued Explain: Decrease the proportion of Montana children who are uninsured and reduce financial barriers to affordable health care coverage. **[500]**	Goal #1: Decrease the proportion of children at or below 150% FPL who are uninsured. **[7500]**	Data Source(s): SCHIP, Medicaid, Caring Program and Children's Special Health Services data systems **[500]** Definition of Population Included in Measure: Children enrolled in SCHIP, Medicaid, and the Caring Program **[700]** Methodology: Unduplicated number of children enrolled in SCHIP, Medicaid, and the Caring Program during FFY 2004 compared with FFY 2003. **[500]** Baseline / Year: (Specify numerator and denominator for rates) FFY 2003 / 74,840 enrolled SCHIP – 13,084 Medicaid – 60,526 Caring – 1,230 **[500]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Performance Progress / Year (Specify numerator and denominator for rates) By the end of FFY 2004, the number of uninsured children decreased by 8,268 due to coverage by SCHIP, Medicaid, and the Caring Program for Children (74,840 (FFY 2003) and 83,108 (FFY 2004)). SCHIP - 15,664 Medicaid – 66,594 Caring – 850 **[7500]** Explanation of Progress: SCHIP and Medicaid continue to refer applications to the appropriate program for the family's needs. **[700]** Other Comments on Measure: **[700]** The 2004 Montana Strategic Planning Grant survey estimates there are 41,500 uninsured children in Montana. Approximately 22,000 reside in households where family income is below 150% of the federal poverty level.
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #2: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #3: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

Objectives Related to SCHIP Enrollment

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
New/revised X Continuing □ Discontinued Explain: **[500]**	Goal #1: Enroll approximately 9,540 children monthly who are at or below 150% FPL during FFY 2004. **[7500]**	Data Source(s): BCBS enrollment for SCHIP. **[500]** Definition of Population Included in Measure: Children at or below 150% FPL who were enrolled during FFY 2004. **[700]** Methodology: Calculate average monthly enrollment and compare it to enrollment target. **[500]** Baseline / Year: (Specify numerator and denominator for rates) 9,540 average number of children enrolled monthly / FFY 2003 **[500]** Performance Progress / Year: FFY 2004 12% increase 9,546 average monthly enrollment in FY03 10,704 average monthly enrollment in FY04 **[7500]** Explanation of Progress: The governor provided $609,900 in one-time funding to enroll children from Montana's waiting list beginning November 2004. This resulted in a 12% increase over FFY 2003. **[700]** Other Comments on Measure: **[700]**
□ New/revised X Continuing □ Discontinued Explain: **[500]**	Goal #2: Increase the reapplication rate to maintain continuous health coverage for SCHIP eligible enrollees. **[7500]**	Data Source(s): SCHIP data system **[500]** Definition of Population Included in Measure: Households that were enrolled at the end of 12 months and needed to re-qualify for coverage. **[700]** Methodology: Compare the number of families whose CHIP coverage is ending (e.g. Oct 31) to the number of renewal applications received from the families (e.g., re-qualify effective Nov 1). **[500]** Baseline / Year: 89% / FFY 2003 (Specify numerator and denominator for rates) **[500]**

		Performance Progress / Year: FFY 2004 (Specify numerator and denominator for rates) 3% decrease FFY 2004 - 4,807 families needed to re-qualify for SCHIP and 4,112 reapplied = 86% reapplication **[7500]** Explanation of Progress: The reapplication rate decreased from 89% in FFY 2003 to 86% in FFY 2004. **[700]** Other Comments on Measure: Due to the time spent developing our new data system, we were unable to conduct an enrollee survey to determine why families were not reapplying. **[700]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #3: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
Objectives Related to Medicaid Enrollment		
□ New/revised X Continuing □ Discontinued Explain: **[500]**	Goal #1: Increase the enrollment of currently eligible but not participating children in the Medicaid Program. **[7500]**	Data Source(s): CHIP data system **[500]** Definition of Population Included in Measure: Children referred for a Medicaid determination based on initial screening by CHIP. **[700]** Methodology: Monitor potentially Medicaid eligible applications referred to Offices of Public Assistance (OPAs) by conducting data file comparisons. **[500]** Baseline / Year: 1,712 children / FFY 2003 (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: 58% increase / FFY 2004 (Specify numerator and denominator for rates) 2,702 (FFY 2004) / 1,712 (FFY 2003) **[7500]** Explanation of Progress: The number of applications referred to county OPAs as potentially eligible for Medicaid was 1,351. This represents approximately 2,702 children. The number of children who were referred as potentially eligible for Medicaid and subsequently enrolled in Medicaid or CHIP is unavailable. **[700]** Other Comments on Measure: **[700]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #2: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #3: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
New/revised X Continuing □ Discontinued Explain: **[500]**	Goal #1: Coordinate with Children's Special Health Services (CSHS), the Mental Health Services Plan (MHSP) Caring Program for Children, Primary Care Association (PCA), Montana Youth Care, Blue Care, Montana Comprehensive Health Association to ensure children and families who need care beyond what is offered by	Data Source(s): **[500]** SCHIP data system Definition of Population Included in Measure: Children screened by CHIP and referred to other programs for health care. **[700]** Methodology: Calculate the number of referrals to other health care programs **[500]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
	CHIP are referred to these programs. □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Baseline / Year: FFY 2003 (Specify numerator and denominator for rates) CSHS – 161 children Caring Program – Approx. 3,746 children MHSP – 8 children **[500]** Performance Progress / Year: FFY 2004 (Specify numerator and denominator for rates) CSHS – 161(FY 2003) /205 children(FY 2004) = 27% Caring – 3,746(FY 2003) /513 children(FY2004 =(86%) MHSP – 8 (FY 2003) /11 children (FY2004) = 27% **[7500]** Explanation of Progress **[700]** Coordination between CSHS and SCHIP continues to improve. Fewer children were referred to MHSP because only children who do not qualify for SCHIP or Medicaid are eligible for MHSP. HIPAA constraints ended referrals to the Caring Program in early FFY 2004. Information about the Caring Program is provided to applicants who are over income for SCHIP and appear potentially eligible for the Caring Program. Information about Community Health Centers (CHC), Nat'l Health Service Corp sites, Migrant & Indian Health clinics is mailed to families who apply for CHIP. CHC state service usage increased by 21% (48,876 in 2002 compared to 59,013 in 2003). Other Comments on Measure: **[700]**
□ New/revised Continuing □ Discontinued Explain: **[500]**	Goal #2: □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #3: □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
□ New/revised X Continuing □ Discontinued Explain: **[500]**	Goal #1: Increase the number of medical and dental providers and facilities available to provide care to CHIP enrollees. □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: X Other Explain: SCHIP medical and dental providers and facilities who provide services to SCHIP enrollees. **[7500]**	Data Source(s): BCBS and SCHIP data systems **[500]** Definition of Population Included in Measure: SCHIP providers **[700]** Methodology: **[500]** Provider enrollment for FYE 2004 was compared to FYE 2003. Baseline / Year: (Specify numerator and denominator for rates) FYE 2003 - 3,294 physicians and allied providers FYE 2003 – 240 dental providers FYE 2003 – 57 facilities **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) Physicians and Allied Providers: 6% increase. There were 3,493 at FYE 2004 compared to 3,294 at FYE 2003. Dental Providers: 5% increase. There were 252 at FYE 2004 compared to 240 at FYE 2003. Facilities: 2% increase. There were 58 hospitals at FYE 2004 compared to 57 at FYE 2003. **[7500]** Explanation of Progress: **[700]** We continue to recruit providers in order to improve access to care for CHIP enrollees. Other Comments on Measure: **[700]**
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #2: □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]**

		Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

(1) Strategic Objectives (specify if it is a new/revised objective or a continuing objective)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
□ New/revised □ Continuing □ Discontinued Explain: **[500]**	Goal #3: □ HEDIS Specify version of HEDIS used: □ HEDIS-Like Explain how HEDIS was modified: Specify version of HEDIS used: □ Other Explain: **[7500]**	Data Source(s): **[500]** Definition of Population Included in Measure: **[700]** Methodology: **[500]** Baseline / Year: (Specify numerator and denominator for rates) **[500]** Performance Progress / Year: (Specify numerator and denominator for rates) **[7500]** Explanation of Progress: **[700]** Other Comments on Measure: **[700]**

1. What other strategies does your state use to measure and report on access to, quality, or outcomes of care received by your SCHIP population? What have you found?

Each quarter we review the total number of dental, physician and hospital SCHIP providers in the state to evaluate network adequacy and access to care. If there is a significant change, we look to assure the change did not leave any region of the state with an inadequate network of providers. It should be noted that Montana is a frontier state with many areas having no, or limited local access to health care for any payer.

Our insurer, Blue Cross Blue Shield (BCBS) of Montana, submits quarterly Health Care Management Reports that summarize costs and utilization of medical and pharmacy services. We meet monthly with BCBS to discuss program changes, successes and challenges. Access to care and quality of care are primary areas of focus.

SCHIP monitors and evaluates the utilization of eyeglasses and dental services. These services are provided on a fee-for-service basis and are not part of the contract with BCBS.

We conduct an annual survey of SCHIP families to assess satisfaction, access to health care services and utilization of insurance benefits. Families are very satisfied with the program (see attached report). Survey results are analyzed and program changes are made when appropriate. **[7500]**

2. What strategies does your SCHIP program have for future measurement and reporting on access to, quality, or outcomes of care received by your SCHIP population? When will data be available?

We will continue the measures listed above. In addition, we will continue to send Explanations of Benefits (EOBs) for eyeglasses and dental services to enrollees who have claims processed for those services. **[7500]**

3. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found?
We did not conduct focused quality studies in FFY 2004. **[7500]**

4. Please attach any additional studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings or list main findings.

2004 CHIP Enrollee Survey Results and Analysis (attached) – This is the summary of an annual survey of families with children enrolled in the Montana CHIP program. The survey assesses patient satisfaction with the CHIP program, CHIP providers and quality of care. In December 2003, 1,000 surveys were mailed to a random sample of CHIP families. Although families might have more than one child enrolled in CHIP, the random sample was based on selecting no more than one child within the same family or household unit. The survey yielded a high response rate of 45%, 454 completed surveys were received.

Findings:

98% of respondents rated their satisfaction with CHIP as very satisfied. On a scale from zero ("completely unsatisfied") to 10 ("completely satisfied") 98% of respondents rated their overall level of satisfaction with the CHIP program at a level 7 or higher. This percentage is slightly higher than the survey last year.

45% rated their provider as the "best personal provider possible" and 88% rated their provider between 7 and 10 (0 being the worst and 10 being the best).

89% rated their understanding of CHIP as high. On a scale from 0 to 10 ("understand the program completely"), 89% rated their overall understanding at a level of 7 or higher. This is a slightly higher percentage than last year.

38% reported their child received preventive care. This is up 9% from 2002 and 6% from last year.

85% surveyed reported their child had not used the emergency room in the last six-month period. This is 1% less than in the last two surveys.

91% reported they felt there was never a time when their child received fewer services than other patients.

98% surveyed rated their dental care as of high quality. On a scale from 0 to 10 ("best dental care possible"), 89% rated their overall understanding at a level of 7 or higher. This is 1% higher than last year. Forty-nine percent (49%) rated dental care as the "best dental care possible," a rate of 10.

77% reported using the BlueCHIP Enrollee Handbook, 99% of those who used the handbook found it very or somewhat useful.
[7500]

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

Please note that the numbers in brackets, e.g., **[7500]** are character limits in the State Annual Report Template System (SARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period?

For most of FFY 2004, we had a waiting list of SCHIP-eligible children. Due to this situation, we chose to focus on educating families whose children were enrolled or on the SCHIP waiting list about health and safety issues. We shared information about the following topics in our quarterly newsletters: staving off obesity and diabetes through good nutrition and exercise, preventing agricultural injuries to children, teenage suicide prevention, car seat and seat belt safety, gun safety, symptoms of pre-term labor, and baby bottle tooth decay.

The SCHIP Community Relations Manager attended several conferences and networked with Montana nurses, medical providers, Women Infants and Children (WIC) staff and Native Americans. We contacted Community Health Clinics, Migrant Health Clinics, Urban Indian Clinics and National Health Service Corps Sites and provided outreach materials and "universal applications" for children's health programs.

SCHIP received $609,900 from Governor Judy Martz in early FFY 2004. With these new funds and matching funds from the federal government, we were able to enroll all the eligible children on the waiting list effective November 1, 2003.
[7500]

2. What methods have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness?

   Although its effectiveness was not measured, the media campaign Montana conducted in August and September 2000 was the most effective outreach activity to date. Contracting with community advocates was also effective in "getting the word out" about CHIP and provided families with assistance in completing the application process. Those contracts were discontinued in December 2001. Last year, due to the lengthy waiting list, we conducted outreach activities listed in our response to Question 1 above.
[7500]

3. Is your state targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)? Have these efforts been successful, and how have you measured effectiveness?

Montana is mostly rural so most of our outreach is directed to rural communities. We distribute current SCHIP informational materials and applications through the schools, meet with Montana employers/employees on request, and attend hospital open houses and community health fairs throughout Montana.

We have continued to visit Montana Native American tribes on a regular basis. This is proving to enhance our relationships with the tribes and has made inroads into educating the different tribes about SCHIP benefits and changes in program policies. Our goal is to see the SCHIP enrollment numbers for Native American children increase in response to our efforts.

Although limiting its outreach activities, Montana is placing emphasis on educating CHIP-eligible families about the effects of chewing tobacco, cigarette, and alcohol use. Information specific to these habits will be mailed to targeted families (i.e., families with children between age 10 and 18). **[7500]**

SUBSTITUTION OF COVERAGE (CROWD-OUT)

States with a separate child health program above 200 through 250% of FPL must complete question 1. All other states with trigger mechanisms should also answer this question.

1. Does your state cover children between 200 and 250 percent of the FPL or does it identify a trigger mechanism or point at which a substitution prevention policy is instituted? Yes _____ No ___X___

   If yes, please identify the trigger mechanisms or point at which your substitution prevention policy is instituted. **[7500]**

States with separate child health programs over 250% of FPL must complete question 2. All other states with substitution prevention provisions should also answer this question.

2. Does your state cover children above 250 percent of the FPL or does it employ substitution prevention provisions? Yes _____ No __X____

   If yes, identify your substitution prevention provisions (waiting periods, etc.). **[7500]**

All States must complete the following 3 questions

3. Describe how substitution of coverage is monitored and measured and the effectiveness of your policies.

   The universal application asks if children currently have health insurance or if they've had health insurance in the past three months. Children must be uninsured for three months before being eligible for CHIP. (Some employment related exceptions apply.)

   The Enrollee Handbook and CHIP material also notify CHIP families that their children are not eligible if they have other health insurance coverage.

   Our insurance plan, Blue Cross Blue Shield of Montana (BCBSMT) compares the CHIP monthly enrollment file with their database for individual and group policyholders and notifies us if a child has other insurance coverage. Since BCBSMT is the largest insurance carrier in the state, we believe this is an effective procedure for monitoring substitution of coverage.

   In addition, providers notify CHIP and BCBSMT if it appears that a CHIP enrollee has other insurance coverage. CHIP staff investigates to determine if other creditable coverage is in effect and, if so, notifies the applicant that the child's CHIP coverage will be terminated.

   We are unable to measure the effectiveness of these policies. **[7500]**

4. At the time of application, what percent of applicants are found to have insurance?

Montana continues to develop its new data system. Until it is fully developed, no data is available regarding the percent of applicants who have insurance at the time of application. **[7500]**

5. Describe the incidence of substitution. What percent of applicants drop group health plan coverage to enroll in SCHIP?

Montana continues to develop its new data system. Until it is fully developed, no data is available regarding the incidence of applicants substituting group health coverage with SCHIP coverage. **[7500]**

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

1. Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.

SCHIP and Medicaid do not have the same redetermination procedures. Medicaid requires documentation of household resources and income as well as any other pertinent changes. SCHIP accepts self-declaration of income. A Quality Assurance Program audits a random sampling of applications with eligible children.

Neither SCHIP nor Medicaid applicants are required to attend a face-to-face interview.

To expedite the renewal process, SCHIP pre-populates its renewal application with information from the family's previous application (e.g., names, dates of birth, ID numbers, etc.). Families must update income information and note other changes (e.g., family members who have moved in or out, etc.), sign, date and return the application so SCHIP can determine whether they continue to qualify for coverage. The pre-populated renewal application has been well received by SCHIP families and has proven to be a time saver for staff. Medicaid does not provide pre-populated applications to families whose Medicaid eligibility must be re-evaluated.

2. Please explain the process that occurs when a child's eligibility status changes from Medicaid to SCHIP and from SCHIP to Medicaid. Have you identified any challenges? If so, please explain.

When a local Office of Public Assistance closes or denies (for a reason other than failure to comply) a child's Medicaid, a copy of the most recent application is forwarded to SCHIP for a determination.

The biggest challenge to this process is ensuring each Medicaid case manager in each of Montana's 56 counties follows the procedure consistently. Montana has worked on developing an electronic file which would ensure SCHIP is notified of all children losing or denied Medicaid. This method of reporting the information would eliminate human error and ensure consistency. Due to the difficulties SCHIP has encountered with developing its new eligibility system, implementation of this electronic file has been postponed. We expect to implement the electronic file in early 2005.

All children who apply for SCHIP are screened for Medicaid eligibility. Applications of those children who are potentially eligible for Medicaid are forwarded to the family's local Office of Public Assistance for a determination of Medicaid eligibility. SCHIP runs a computer match against Medicaid files for these referrals. SCHIP coverage is denied for children who are determined Medicaid eligible. Children who are ineligible for Medicaid will be eligible for SCHIP if all other eligibility criteria are met. Children eligible for SCHIP are placed on the waiting list until funds are available to enroll them. **[7500]**

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

The delivery systems for SCHIP and Medicaid are not the same although the providers are often enrolled in both programs' networks. SCHIP contracts with Blue Cross Blue Shield of Montana (BCBSMT) to enroll and provide support for medical, allied and hospital providers. SCHIP contracts with Affiliated Computer Services Inc. (ACS) to enroll and support dental and eyeglasses providers. SCHIP, Medicaid and the Department of Corrections have a bulk-purchasing contract for eyeglasses. The contractor is Walman Optical, Inc. Medicaid enrolls and supports its medical, allied and dental providers through its contractor, ACS. CHIP medical provider enrollment and support is provided by our contractor BCBS. SCHIP and Medicaid state staff also provide support for their respective networks and delivery systems. **[7500]**

ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures does your State employ to retain eligible children in SCHIP? Please check all that apply and provide descriptions as requested.

_____ Conducts follow-up with clients through caseworkers/outreach workers

X Sends renewal reminder notices to all families

3 *How many notices are sent to the family prior to disenrolling the child from the program?* _____ **[500]**

At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the State?) The following renewal mailings are sent to families: 1) a postcard is mailed 9 ½ months after eligibility was determined which indicates the renewal application will be sent shortly, 2) the pre-populated renewal application is mailed 10 months after eligibility was determined; and 3) a reminder notice is mailed 11 months after eligibility is determined, if the renewal application was not returned. **[500]**

_____ Sends targeted mailings to selected populations

Please specify population(s) (e.g., lower income eligibility groups) **[500]**

_____ Holds information campaigns

X Provides a simplified reenrollment process,

Please describe efforts (e.g., reducing the length of the application, creating combined Medicaid/SCHIP application) SCHIP provides families with a four page pre-populated renewal application. The family notes changes to the information (e.g., family members who have moved, school attendance, etc) plus enters current income received. Renewal applications for individuals who are potentially eligible for Medicaid are forwarded for a determination of Medicaid eligibility. **[500]**

_____ Conducts surveys or focus groups with disenrollees to learn more about reasons for disenrollment

please describe: During FFY 2004, SCHIP did not conduct a survey of disenrollees to determine the reasons for disenrollment. **[500]**

_____ Other*, please explain*: **[500]**

2. Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology.

   Improving the renewal materials and implementing a renewal application that was shorter and easier to complete resulted in an increased number of returned renewal applications, reduced the time required to process the application and resulted in more CHIP children receiving continuous coverage. **[7500]**

3. Does your State generate monthly reports or conduct assessments that track the outcomes of individuals who disenroll, or do not reenroll, in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, how many move to a new geographic area)

   __X___Yes

   _ ____No

   When was the monthly report or assessment last conducted? Information is for FFY 2004.

   Montana has previously surveyed families who did not reapply for SCHIP. However, due to the demands of developing our new data system, we were unable to survey families during FFY 2004. **[7500]**

If you responded yes to the question above, please provide a summary of the most recent findings (in the table below) from these reports and/or assessments. **[7500]**

Findings from Report/Assessment on Individuals Who Disenroll, or Do Not Reenroll in SCHIP

Total Number of Dis-enrollees	**Obtain other public or private coverage**		**Remain uninsured**		**Age-out**		**Move to new geographic area**		**Other (State employee, Death, Audits, etc.)**	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
3,594	1,997	55.56	N/A	N/A	336	9.35	322	8.96	939	26.13

Please describe the data source (e.g., telephone or mail survey, focus groups) used to derive this information. SCHIP data system **[7500]**

COST SHARING

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found? **[7500]**

   N/A

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found? **[7500]**

   During the FFY 2003 SCHIP Survey of Families Who Did Not Renew CHIP Coverage for July 2003, families were asked their reasons for not re-applying for SCHIP and cost-sharing was not mentioned as a barrier by respondents.

3. If your state has increased or decreased cost sharing in the past federal fiscal year, has the state undertaken any assessment of the impact of these changes on application, enrollment, disenrollment, and utilization of health services in SCHIP. If so, what have you found? **[7500]**

   N/A

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program for children and/or adults using Title XXI funds under any of the following authorities?

   Yes _____ please answer questions below.

   No ___X___ skip to Section IV.

Children

____ Yes, Check all that apply and complete each question for each authority.

____ Premium Assistance under the State Plan

Family Coverage Waiver under the State Plan

____
____ SCHIP Section 1115 Demonstration
____ Medicaid Section 1115 Demonstration
____ Health Insurance Flexibility & Accountability Demonstration
____ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

Adults

____ Yes, Check all that apply and complete each question for each authority.
____ Premium Assistance under the State Plan (Incidentally)
____ Family Coverage Waiver under the State Plan
____ SCHIP Section 1115 Demonstration
____ Medicaid Section 1115 Demonstration
____ Health Insurance Flexibility & Accountability Demonstration
____ Premium Assistance under the Medicaid State Plan (Section 1906 HIPP)

2. Please indicate which adults your State covers with premium assistance. (Check all that apply.)

____ Parents and Caretaker Relatives

____ Childless Adults

3. Briefly describe your program (including current status, progress, difficulties, etc.) **[7500]**

4. What benefit package does the program use? **[7500]**

5. Does the program provide wrap-around coverage for benefits or cost sharing? **[7500]**

6. Identify the total number of children and adults enrolled in the premium assistance program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).

_____ Number of adults ever-enrolled during the reporting period
_____ Number of children ever-enrolled during the reporting period

7. Identify the estimated amount of substitution, if any, that occurred or was prevented as a result of your premium assistance program. How was this measured? **[7500]**

8. During the reporting period, what has been the greatest challenge your premium assistance program has experienced? **[7500]**

9. During the reporting period, what accomplishments have been achieved in your premium assistance program? **[7500]**

10. What changes have you made or are planning to make in your premium assistance program during the next fiscal year? Please comment on why the changes are planned. **[7500]**

11. Indicate the effect of your premium assistance program on access to coverage. How was this measured? **[7500]**

12. What do you estimate is the impact of premium assistance on enrollment and retention of children? How was this measured? **[7500]**

13. Identify the total state expenditures for family coverage during the reporting period. **(For states offering premium assistance under a family coverage waiver only.) [7500]**

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period =Federal Fiscal Year 2004. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED SCHIP PLAN

Benefit Costs	**2004**	**2005**	**2006**
Insurance payments	151,797,930	**15,426,552**	**16,198,272**
Managed Care	0	0	0
per member/per month rate @ # of eligibles	0	0	0
Fee for Service	1,414,778	**1,437,729**	**1,509,615**
Total Benefit Costs	16,594,571	**16,864,281**	**17,707,887**
(Offsetting beneficiary cost sharing payments)	0		
Net Benefit Costs	**$16,594,571**	**$16,864,281**	**$17,707,887**

Administration Costs			
Personnel	522,742	525,000	525,000
General Administration	475,553	476,553	476,553
Contractors/Brokers (e.g., enrollment contractors)	0	0	0
Claims Processing	82,422	82,422	82,422
Outreach/Marketing costs	7,500	7,500	7,500
Other **[500]**	0	0	0
Health Services Initiatives	0	**0**	**0**
Total Administration Costs	1,088,217	**1,091,475**	**1,091,475**
10% Administrative Cap (net benefit costs ÷ 9)	1,843,841	**1,873,809**	**1,967,543**

Federal Title XXI Share	14,323,058	**14,423,859**	**15,101,527**
State Share	3,359,730	**3,531,897**	**3,697,835**

TOTAL COSTS OF APPROVED SCHIP PLAN	17,682,788	**17,955,756**	**18,799,362**

NOTE: Montana has been notified that the estimated FMAP for FFY 2006 will be 79.38%. However, SARTS used the FFY 2005 (80.33%) FMAP to calculate FFY 2006 federal and state shares. Using 79.38%, we estimate the federal share to be $14,922,934 and the state share to be $3,876,428.

Budget Assumptions:

2004 – average monthly enrollment was 10,706 @ $117.94/mo. insurance premium and $11/mo. fee-for-service (dental and eyeglasses).

2005 – enrollment estimated at 10,900 enrollees per month @ $117.94/mo insurance premium and $11/mo fee for service (dental and eyeglasses). Increased personnel estimate due to staff salary increases effective January 1, 2005. Minimal increase in general administration expense estimated.

2006 – estimated a 5% increase in benefit costs; enrollment estimated at 10,900 enrollees @ $123.84/mo insurance premium and $11.54/mo fee for service (dental and eyeglasses). Administrative expenses maintained at 2005 level.

2. What were the sources of non-Federal funding used for State match during the reporting period?

X	State appropriations
	County/local funds
	Employer contributions
	Foundation grants
	Private donations
X	Tobacco settlement
	Other (specify) **[500]**

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

Please reference and summarize attachments that are relevant to specific questions.

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Parents	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Childless Adults	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL
Pregnant Women	From		% of FPL to		% of FPL	From		% of FPL to		% of FPL

2. Identify the total number of children and adults ever enrolled (an unduplicated enrollment count) in your SCHIP demonstration during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What have you found about the impact of covering adults on enrollment, retention, and access to care of children?

4. Please provide budget information in the following table for the years in which the demonstration is approved. *Note: This reporting period (Federal Fiscal Year 2004 starts 10/1/03 and ends 9/30/04).*

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	**2004**	**2005**	**2006**	**2007**	**2008**
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #1					
Benefit Costs for Demonstration Population #2 (e.g., parents)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					

Fee for Service					
Total Benefit Costs for Waiver Population #2					

Benefit Costs for Demonstration Population #3 (e.g., pregnant women)

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Benefit Costs for Demonstration Population #4 (e.g., childless adults)

Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #3					

Total Benefit Costs					
(Offsetting Beneficiary Cost Sharing Payments)					
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)					

Administration Costs

Personnel					
General Administration					
Contractors/Brokers *(e.g., enrollment contractors)*					
Claims Processing					
Outreach/Marketing costs					
Other *(specify)* **[500]**					
Total Administration Costs					
10% Administrative Cap (net benefit costs ÷ 9)					

Federal Title XXI Share					
State Share					

TOTAL COSTS OF DEMONSTRATION					

When was your budget last updated (please include month, day and year)? **[500]**

Please provide a description of any assumptions that are included in your calculations. **[7500]**

Other notes relevant to the budget: **[7500]**

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

1. For the reporting period, please provide an overview of your state's political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted SCHIP.

   National and state economic conditions have resulted in a tight budget for Montana. One of Montana's biggest challenges has been funding health care costs for needy Montanans. In October 2003, Governor Martz provided SCHIP with a one-time funding of $609,900. The purpose of the funding was to enable enrollment of children off the waiting list – some of whom waited from six to eight months before being enrolled.

   In November 2004, Montanans voted to pass Initiative I-149 that increased tobacco taxes. A portion of the revenue generated from the tax increase will be funneled into SCHIP. At this time, it's unknown what the funding amount will be.

   Additionally, Montana's Community Health Centers, National Health Service Corp sites, Migrant and Indian Health clinics have reported a marked increase in services to low income or uninsured children and families. Service usage increased by 21% from 2002 to 2003 (most recent data available).

   [7500]

2. During the reporting period, what has been the greatest challenge your program has experienced?

   The greatest challenge Montana experienced was the development of the SCHIP data system. Montana had hoped to have the system in production by March 2004. However, because of the labor-intensive process and limited funding, it was not placed into service until late September 2004. The new system continues to present challenges that are addressed as they arise. Eligibility determination, enrollment and data collection functions have all been impacted.

   Additionally, SCHIP had hoped to purchase an electronic filing system during FFY 2004 that would streamline the eligibility determination process and reduce storage costs. To ensure the most favorable pricing, SCHIP is awaiting purchasing decisions by other state agencies. **[7500]**

3. During the reporting period, what accomplishments have been achieved in your program?

   1) In October 2003, Montana's governor provided a "one-time funding" of $609,900 which enabled SCHIP to enroll all the eligible children from the waiting list. This increased the enrollment to 10,900 children. Some children had been awaiting enrollment for six to eight months.
   2) Montana negotiated its FFY 2005 contract with Blue Cross Blue Shield and premiums did not increase.
   3) The SCHIP insurance contractor, BCBSMT, will be refunding more than $2 million to SCHIP in FFY 2005. These funds will be used to pay insurance premiums for SCHIP enrollees.
   4) Increased contact and rapport with Montana's Native Americans.
   5) Improved the coordination of services with Children's Special Health Services.
   6) Increased outreach efforts to local Offices of Public Assistance to assure continued communication and coordination.
   7) Streamlined the application referral process between the Offices of Public Assistance and SCHIP.
   8) Montana's SCHIP records retention schedule was approved.
   9) All SCHIP staff completed HIPAA training and the Department's coordinator approved our HIPAA compliance plan.
   10) Montana has stepped up its efforts to provide prevention education to families. Our quarterly newsletters have included articles regarding prevention of childhood obesity, agricultural injuries to children, teen suicide, and baby bottle tooth decay.
   11) A VISTA volunteer started working with SCHIP in July 2003. The volunteer will be writing grants on behalf of SCHIP, assisting with outreach and public education, and applying for 501(c)(3) status so Montana can accept donated funds.

12) Conducted a CHIP Provider Survey (see attached report). **[7500]**

4. What changes have you made or are planning to make in your SCHIP program during the next fiscal year? Please comment on why the changes are planned.

    1) Montana's legislature will convene in January 2005. We will work with agency staff and legislators in an effort to increase SCHIP funding so more children can be insured.
    2) We will work to obtain funding through grants and donations to enable SCHIP to maintain and possibly increase enrollment.
    3) Montana's State Plan will be reviewed and amended, as appropriate.
    4) Montana hopes to implement a paperless (electronic) filing system to improve the efficiency of the SCHP eligibility determination, enrollment and referral processes.
    5) We will work with our contractor, Northrup Grumman, to finalize the implementation of our eligibility, enrollment and reporting system. **[7500]**